Case Number:	CM13-0033254		
Date Assigned:	03/03/2014	**Date of Injury:**	03/31/2009
Decision Date:	05/09/2014	**UR Denial Date:**	09/16/2013
Priority:	Standard	**Application Received:**	10/09/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 34 year old female who was injured on 03/31/2009 while she was walking to the nurse's station when she slipped and fell. She immediately noted a sharp pain in her left hand and left knee. She noted swelling of the left hand but not of the left knee. Prior treatment history has included medications, 12 physical therapy sessions, 24 sessions of acupuncture treatment, a TENS unit, ice, wrist splint and Motrin. Diagnostic studies reviewed include an MRI of the left wrist, left shoulder, neck and left elbow that was performed which showed built-up fluid, left rotator cuff injury, built-up fluid in left elbow and scar tissue at back of left wrist. A progress note dated 08/23/2013 documented the patient to have complaints of constant left shoulder pain which she rates 7-8/10. The pain radiates down to her arm, elbow and fingertips. She also has complaints of constant pain in the left wrist which she rates 6/10. She has constant pain of the left elbow which she rates 6-7/10. Objective findings on exam included examination of the neck and upper extremities, cervical flexion 50 degrees, extension 40 degrees, and lateral tilting 30 degrees bilaterally. Evaluation of neurological function, deep tend reflexes were symmetric and bilaterally at biceps, triceps and brachioradialis. Sensation is intact throughout the bilateral upper extremities. Two-point discrimination is normal in bilateral upper extremities. Reverse Phalen's positive on the left, although nonspecific and negative on the right. Phalen's is positive on the left and negative on the right. Hyperflexion test is negative bilaterally. Strength is 5/5. On evaluation of impingement, positive impingement mild on the left and negative on the right. Speed's test equivocal on the left and negative on the right. Cross arm test negative on the right as well as no tenderness on AC joint and negative O'Brien test. On the left there is tenderness along the AC joint, negative cross arm test and negative Obrien test. Negative lift off test on the left. No pain along the right shoulder. She has tenderness along rotator cuff, biceps tendon and AC joint on the left. At the wrist, negative Tinel's on the left wrist and positive on the right. She has carpal tunnel

on both wrists bilaterally. There is no atrophy at the APB. Tinel's negative at the right and left elbow. Negative subluxation on the ulnar nerve, right and left. No Tinel's along supraclavicular, infraclavicular or scalene. She has pain with facet loading of the cervical spine as well as pain along the facets on the left and on the right. Along the left elbow, she has tenderness along the medial and lateral epicondyle and to resisted function. She also has tenderness along the radial tunnel on the left. No tenderness along the cubital tunnel on the left. She has tenderness along the extensors of the right as well as positive intersection along the distal forearm bilaterally. She has a 1 inch incision on the left wrist which is well healed. The patient has mild tenderness along palmar-ulnar carpal and radial joint as well as pisohamate. No tenderness along CMC or SC joint on the left side. On evaluation of back and lower extremities, the patient has a normal gait. Gait is fluid, well balanced and even paced. Milligram's test is negative. Tight hamstring at 70 degrees on the right and 90 degrees on the left. Hip flexion is 90 degrees bilaterally. Patrick's test is negative bilaterally. Mild crepitation with range of motion of the left hip and knee and negative on the right. Abduction 35 degrees left and external rotation 60 degrees on left and 50 degree s on right, internal rotation 30 degrees on right and 20 degrees on left, extension at the knee s is 120 degrees with no pain, degrees on the left with pain along the medial and lateral joint line. Negative anterior drawer test on the left and negative Lachman's test on the left. Negative McMurrays medially and laterally on the left. No tenderness along the inner patella and no tenderness along the outer patella. Negative patellar tilt test. Positive compression test. Negative inhibition test on the left. Dorsiflexion is 15 degrees and plantar flexion 30 degrees bilaterally.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

MRI OF CERVICAL SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

Decision rationale: The ACOEM Guidelines state the criteria for ordering imaging studies are: Emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; and Clarification of the anatomy prior to an invasive procedure. The medical records do not establish progressive neurological deficit, there is no evidence of an emergence of a red flag, and the patient is not pending invasive procedure. The medical necessity of a cervical MRI has not been established. The request is not medically necessary and appropriate.

MRI OF LEFT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

Decision rationale: ACOEM Guidelines state, "Primary criteria for ordering imaging studies are:- Emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems); - Physiologic evidence of tissue insult or neurovascular dysfunction (e.g.,cervical root problems presenting as shoulder pain, weakness from massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon); - Failure to progress in a strengthening program intended to avoid surgery; - Clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment)." According to the Official Disability Guidelines, some of the indications for Magnetic resonance imaging (MRI) of the shoulder are include acute shoulder trauma, suspect rotator cuff tear/impingement; and an age over 40. The medical records provided for review do not establish that criteria for an MRI of the shoulder have been met. There is no evidence of recent injury or trauma, significant change in the patient's clinical findings. The patient has apparently already undergone an MRI of the left shoulder, with findings noted. Repeat MRI is not recommended, in absence of significant change in symptoms and findings suggestive of significant pathology. The medical necessity of left shoulder MRI has not been established. The request is not medically necessary and appropriate.

MRI OF THE LEFT ELBOW: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): ELBOW, INDICATIONS FOR IMAGING- MAGNETIC RESONANCE IMAGING (MRI).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation NON-MTUS.

Decision rationale: The medical records provided for review do not establish the criteria for ordering MR imaging of the elbow have been met. In addition, the medical records indicate an MRI of the elbow showed build-up of fluid. Repeat MRI's of the elbow are to be reserved for significant change in symptoms and/or findings of significant pathology. The medical necessity of left elbow MRI has not been established. The request is not medically necessary and appropriate.

MRI OF LEFT WRIST: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): FOREARM, WRIST AND HAND-INDICATIONS FOR IMAGING--MAGNETIC RESONANCE IMAGING (MRI).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: The medical records provided for review do not establish the patient meets any of the criteria for which an MRI of the wrist is warranted. According to the medical records, several MRIs of the wrist revealed ganglion cyst/torn ligament/torn tendon. Also, diagnostic

studies include an MRI of the left wrist that revealed scar tissue at back of left wrist. There is no evidence of significant change in symptoms and/or findings suggestive of significant pathology. The medical necessity of left wrist MRI has not been established. The request is not medically necessary and appropriate.

REPEAT EMG OF THE BILATERAL UPPER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

Decision rationale: According to the ACOEM guidelines, Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. There are no complaints or significant findings involving the right upper extremity, and so special testing is not warranted. Also, apparently, an EMG of the upper extremities had been performed. The medical records do not establish severe or progressive neurological deterioration, in which case a repeat EMG is not medically necessary and appropriate.

IN HOME TENS UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, CHRONIC PAIN (TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, CHRONIC PAIN (TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION) Page(s): 114 and 115.

Decision rationale: According to the MTUS Chronic Pain Guidelines, TENS is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the following conditions: Neuropathic pain, Phantom limb pain and CRPS II, spasticity, and multiple sclerosis. The medical records do not demonstrate the patient has any of these conditions. Furthermore, the medical records provided for review do not establish this patient has failed standard interventions. The request is not medically necessary and appropriate.

DME: SOFT AND RIGID BRACE ON LEFT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: According to the ODG, the term DME is defined as equipment which: (1) Can withstand repeated use, i.e., could normally be rented, and used by successive patients;(2) Is primarily and customarily used to serve a medical purpose;(3) Generally is not useful to a person in the absence of illness or injury; &(4) Is appropriate for use in a patient's home. The medical records do not specify for what body part the brace device is requested for. The guidelines criteria have not been met. Therefore, in absence of this relevant information, the medical necessity has not been established.

DME: HOT AND COLD WRAP FOR THE WRIST AND ELBOW: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), COLD PACKS.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: According to the ODG, at-home local applications of cold packs first few days of acute complaints; thereafter, applications of heat packs are recommended. Simple at home applications of heat and cold can suffice for delivery of heat or cold therapy. In accordance with the guidelines, the medical necessity of a hot and cold wrap is not established. The request is not medically necessary and appropriate.

DME: CERVICAL COLLAR: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, COLLARS (CERVICAL).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174.

Decision rationale: The ACOEM Guidelines state "cervical collars have not been shown to have any lasting benefit, except for comfort in the first few days of the clinical course in severe cases; in fact, weakness may result from prolonged use and will contribute to debilitation. According to ODG, a cervical collar may be appropriate where post-operative and fracture indications exist, it is not recommended for neck sprains. The use of cervical collars is not recommended or supported by the medical literature. A cervical collar is not medically necessary.

DME: LEFT KNEE BRACE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: Examination documents the patient demonstrated a normal, non-antalgic, fluid gait. Examination of the left knee does not reveal any findings suggestive of instability. She has not undergone knee surgery. The medical records do not establish the patient has any of the conditions for which a knee brace may be indicated. The medical records do not establish the requested knee brace is appropriate and medically necessary for this patient.

MEDROX PATCHES #20: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS, Page(s): 111-1113.

Decision rationale: Medrox is a topical product that contains methyl salicylate 5%, menthol 5%, and capsaicin 0.0375%. According to the MTUS Chronic Pain Guidelines, topical analgesics are considered to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. Capsaicin may be recommended as an option for patients who have not responded or are intolerant to other treatments. The medical records do not establish that to be the case of this patient. In addition, the Guidelines state there have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. The medial necessity of Medrox patches has not been established. The request is not medically necessary and appropriate.

TEROCIN LOTION 4 OZ: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, 111-113

Decision rationale: Terocin lotion contains lidocaine and menthol. According to the MTUS Chronic Pain Guidelines, only Lidocaine in the formulation of Lidoderm patch may be considered for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica). The medical records do not establish neuropathic pain. The guidelines state no other commercially approved topical formulations of lidocaine are indicated for neuropathic pain. Only FDA-approved products are currently recommended. Topical lidocaine is not recommended for non-neuropathic pain. The medical records do not establish Terocin lotion is medically necessary for this patient.

PRILOSEC 20MG, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS & CARDIOVASCULAR RISK Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI SYMPTOMS, AND CARDIOVASCULAR RISK Page(s): 68.

Decision rationale: The MTUS Chronic Pain Guidelines state medications such as omeprazole (Prilosec) may be indicated for patients at risk for gastrointestinal events, which should be determined by the clinician: 1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The medical records do not establish any of these potential risk factors apply to this patient. The medical records do not establish the patient is at risk for gastrointestinal events, to warrant access to the proton pump inhibitor. The request is not medically necessary and appropriate.

ACETADRYL 25/500MG, #50: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES - TREATMENT FOR WORKERS' COMPENSATION , 9TH EDITION (WEB): INSOMNIA TREATMENT.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), and WebMD, http://www.webmd.com/drugs/drug-156059-Acetadryl+Oral.aspx?drugid=156059&drugname=Acetadryl+Oral.

Decision rationale: Acetadryl is a combination product that contains 2 medications, acetaminophen and an antihistamine. Acetaminophen and antihistamine are standardly available as individual medications. There is no subjective report of allergy or cold symptoms. It is also noted that the antihistamine in this product may cause drowsiness; however the medical records do not establish complaints and objective findings/observations indicating active insomnia. The medical records do not establish medical necessity for the combination drug, Acetadryl.

TRAMADOL ER 150MG, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 78, 93-94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS SPECIFIC DRUG LIST, Page(s): 82-83, 93-94.

Decision rationale: According to the MTUS Chronic Pain Guidelines, the lowest possible dose should be prescribed to improve pain and function. Tramadol ER is potent form of opiate analgesic. The MTUS Chronic Pain Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. The medical records do not demonstrate failure or exhaustion of first-line therapies and self-care measures utilized by the patient to address pain levels. Based on the patient's documented history, subjective complaints and objective findings, a non-opioid medication would be applicable to addressing her pain complaints. The medical necessity of Tramadol ER has not been established.